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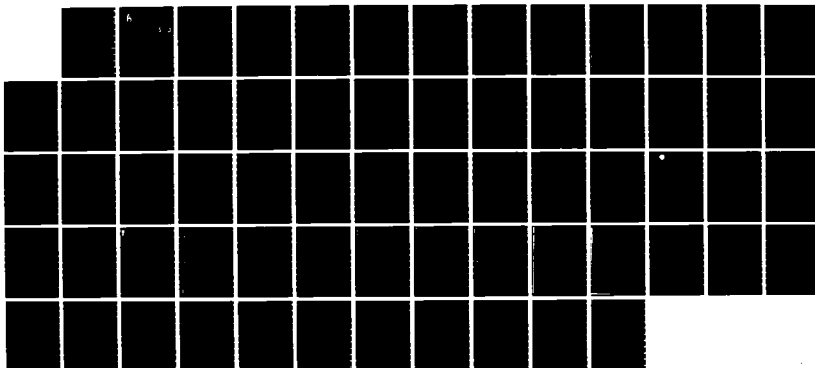
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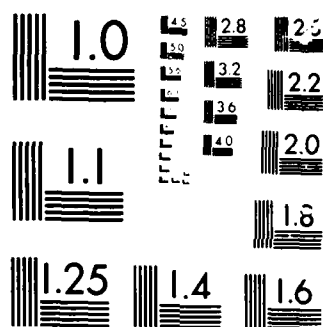
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WASHINGTON D.C.



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FEASIBILITY STUDY FOR THE ESTABLISHMENT OF A
NURSE ADMINISTERED UNIT AT
WALTER REED ARMY MEDICAL CENTER

FINAL REPORT

LTC Susan McMarlin
LTC James D. Vail
LTC Jude Larkin

Report # MR86-001

April 1986

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US ARMY
HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234

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19. ABSTRACT (Continue on reverse if necessary and identify by block number) The purpose of the study was to explore the possibility of establishing a Nurse Administered Unit (NAU) at Walter Reed Army Medical Center (WRAMC), Washington, D.C. The rationale for a NAU is to improve the quality of care for selected patients while simultaneously reducing the cost of the care administered. The objectives for the study are: (1) To explore the incentives for the implementation of a NAU, (2) To provide information on the current status of selected NAUs located in the civilian sector, (3) To propose the number of nurses and other personnel needed to staff the unit, (4) To identify the number of patient beds and the possible space or location which could house the NAU at WRAMC, and (5) To explore the impact of the NAU upon the resources needed to establish the proposed unit. Methodology for the study consisted of interviews with knowledgeable informants, a review of the literature, discussions with other health professionals having experience in or with NAUs, and site visits to facilities having NAUs. (Continued)					
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Item 19, ABSTRACT, (Continued)

Findings of this study include: (1) NAUs in both the private and public (VA) sector have been in successful operation for years and report considerable savings to utilizing institutions; (2) Wards 61, 62, or 63 at WRAMC could be used for a NAU with minimal impact on the organization - no inpatient beds would be displaced and no structural changes would have to be made; (3) initially, a 12-bed unit would be utilized; (4) a staffing mix with one O5/Ph.D., one O-4/MSN, three O-3/MSN-BSN, one O-2/BSN, two GS-11/MSN professional nurses and one 91C30 NCOIC as well as six 91A enlisted medical personnel would be utilized; and (5) four MRTs/GS-4 would be needed for the day and evening shifts.

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1. Project Title: Feasibility Study for the Establishment of a Nurse Administered Unit at Walter Reed Army Medical Center, Washington, DC.

2. Project Director: Eily P. Gorman, COL, AN
Assistant Chief, Army Nurse Corps

Principal Investigator: Susan A. McMarlin, LTC, AN

Associate Investigators: James D. Vail, LTC, AN
Jude Larkin, LTC, AN
Nursing Research Service
Department of Nursing
Walter Reed Army Medical Center
Washington, DC 20307-5001

Purpose: To explore the possibility of establishing a Nurse Administered Unit (NAU) at Walter Reed Army Medical Center, Washington, DC. The rationale for a NAU is to improve the quality of care for selected patients while simultaneously reducing the cost of the care administered.

3. Objectives for Phase I of the study are:

a. To explore the incentives for the implementation of a Nurse Administered Unit.

b. To provide information on the current status of selected Nurse Administered Units located in the civilian sector.

c. To propose the number of nurses and other personnel needed to staff the unit.

d. To identify the number of patient beds and the possible space location which could house the unit at Walter Reed Army Medical Center.

e. To explore the impact upon the resources needed to establish the proposed unit.

4. NURSING/MEDICAL APPLICATION: There is national concern about the escalating costs of hospital care. Acute care hospitals have been under scrutiny and attack in regard to their part in the exorbitant and ever-increasing cost of health care. Hospitals are under pressure to control their costs and still ensure quality care to those needing the services. The primary focus of a Nurse Administered Unit is to provide individualized nursing care to those patients who no longer need daily physician attention but would benefit from continued nursing therapies. The cost for an occupied bed on another unit requiring advanced medical technology would be greater than an occupied bed on a unit dedicated to providing nursing therapies.

Some of the benefits which could be realized from having a NAU at Walter Reed Army Medical Center are:

- a. Extensive nursing care would be provided by a highly efficient nursing staff.
- b. Physicians would be freed to focus on patients requiring daily physician care.
- c. The cost of a bed administered by nurses would be less expensive than beds on other units requiring sophisticated equipment and medical attention.
- d. The conversion of bed space formally used for offices or administrative purposes to patient beds would add to the MCCUs for the hospital.
- e. The rehabilitative and educational services rendered to the patients could result in shorter hospital stays and increase times between readmissions.
- f. The NAU would provide additional opportunities for studying nursing therapies and ultimately could add to the store of nursing knowledge.
- g. The hospital center would be recognized as being the first military hospital to house a NAU. Its existence could be used for recruitment and other similar activities.

5. STATUS:

During the past decade, many nurses have been educated in the skills and theory of primary care delivery. These nurses are emerging as professionals who are prepared to assess and diagnose individual responses to deviations from health, manage care in certain illnesses, and plan and promote the maintenance of health. Recent studies conducted by the federal Office of Technical Assistance (OTA), the Health Care Financing Administration (HCFA), Kaiser-Permanente and others indicate that between 60 and 80 percent of primary care activities which were previously considered part of the role of the physician--can be assumed by nurses with advanced education without a decrease in quality (Lundeen, 1985).

There is national concern about the rapidly escalating costs of health and hospital care. Widespread effort has been launched to reduce unnecessary costs and hospitalizations by having physicians perform as many diagnostic and therapeutic procedures as possible on an ambulatory basis. Presumably, more patients are being hospitalized because they require continuing nursing care and ready access to physician services (Walker, 1983).

Nurse administered units are being established to provide an environment for the management of patients who no longer require daily physician care, but need substantial nursing care before returning to their previous living arrangements. These structures in no way exclude physicians or other members of the interdisciplinary team, but call for a reorganization of the staffing pattern usually reported for primary care centers. Although there are no nurse administered units within the AMEDD Health Care System, there are numerous examples in the civilian sector whose concepts could be effectively adapted to a military setting. A review of some of these contemporary systems provides the substance for a model which could benefit a specific group of patients being treated in military hospitals.

Montefiore Hospital is recognized as a forerunner in the development of alternate systems of patient care other than the acute hospital setting. The Loeb Center is affiliated with Montefiore, and admits patients from acute hospital units who no longer are in biological crisis but still required nursing care on a twenty-four hour basis and medical supervision and evaluation on a daily basis (Hall, et al, 1975). When the Loeb Center admitted its first patient in 1963, the major organization delivery of nursing care in hospitals was team or functional assignment. This fractionalization of nursing care had made it almost impossible for the nurses to find the time to spend with the patient. The system of nursing proposed at the Loeb Center fostered the "case concept" similar to that most common in public health nursing. Registered nurses provide the physical care, the activities of daily living, and determine a patient's eligibility for a program of continuing hospital care.

Predictions that the center would become nothing more than a "nursing home"--and too expensive an operation for the services it would deliver did not come true. A 1975 study was conducted to determine whether patients experienced any difference in outcome when Loeb Center was a part of their hospital experience as contrasted with those patients whose total experience was in the general hospital setting (op. cit., p. 94). Participants included 539 patients of which 351 were admitted to Loeb Center, and 188 were considered controls and left in the acute care setting. Results indicated that the Loeb patients fared better

and at less overall cost. For example, more of the controls experienced multiple rehospitalizations and went to nursing and convalescent homes. A significant different amount of the Loeb patients returned to work and maintained or were involved with social group activities.

Veteran Administration Hospitals have been in the forefront in the development of special programs to improve patient management techniques while making conscious efforts to save money (Zauzmer, 1985). The Center for Nursing Therapy at the Audie Murphy Veteran's Hospital, San Antonio, Texas is one of two nurse administered units at the hospital which has successfully operated for more than ten years (see Appendix A). Twelve registered nurses plus clerical assistance staff the thirty-bed area designed for the care of patients whose condition has stabilized. The source of the patients in the NAU are usually from intensive care units in the hospital. Their stay in the Center ranges from several days to months with an average of six days. Nurses provide a forum for patient education and additional nursing therapies prior to the discharge of the patient (Alfano, 1980). Teaching and home self-care are incorporated into the care plan of patients with such problems as diabetes mellitus, cancer, wounds, mobility impairments, ostomies, hypertension, and weight reduction.

Patient teaching begins at admission to the NAU at the Audie Murphy Hospital and continues through the process of planning for discharge. The unit is reputed to be unique in its ability to provide individualized nursing care as nurses function in expanded roles within a limited physician directed setting. Patients are admitted to the NAU after being assessed by the nursing administrator to determine if the patient can benefit from additional nursing therapies. The patients are primarily self care but may include those patients which require partial or total assistance with their care including medications. The unit is considered to be cost effective in terms of the overall price of the hospitalization, patient compliance after discharge, and less frequent return of the patients to the hospital or clinics after release from the hospital (Braulick, et al, 1983).

Another thirty bed, nurse managed unit located at the Veterans' Administration Medical and Regional Office Center in White River Junction, Vermont, has demonstrated that a high percentage of chronically disabled patients can be discharged to independent living (Nelson, 1984). Although the degree of overall disability did not significantly diminish between admission and discharge during one year under study, eighty-five percent of the 117 patients discharged returned to independent living. The credit for the unusually high rates lay in its comprehensive program run primarily by nurses. The study extending from 1980-1981 reported that the nurse coordinated,

rehabilitation-oriented, health team approach can prevent both extended hospitalization and undue institutionalization (ibid). Through a structured, individualized adjustment process, the staff assisted patients to assimilate therapeutic outcomes into their former life styles and involved significant others in the program of care. Appropriate follow-up has been shown to minimize the need for readmissions.

New York University Medical Center Cooperative Care shares a similar philosophy with those operating Nurse Administered Unit (Cooperative Care, Am J of Care for the Aging, 1981). Co-op Care opened in April 1979 and served over 5,000 patients and their partners during that time. There are thirty-six nurses at Cooperative Care. Among the staff are four nurse educators and twenty-five nurse clinicians. Requirements for most positions include a bachelor's degree in nursing, three years experience in acute medical-surgical nursing, and a commitment to practice in a manner that differs sharply from nursing in the traditional hospital setting.

Cost to the patient in Co-op Care is forty percent less than the daily University Hospital charge. A primary reason for the less expensive rate cost is because oxygen and suction are not piped into the rooms of the patients and the partners of the patients assist with a great deal of the personal care services. Another cost saving benefit is associated with the high retention rate of the nurses. Cooperative Care has been described in management and hospital literature (Hosp. Manag. Q., 1979). The current medical director believes the concept will spread because the idea is a new and exciting innovation that delivers cost-effective and excellent care. The nurses are credited with being the secret ingredient for the success of the pioneer program which was based on the recognition of the tremendous need for additional teaching of the hospitalized patient (see Appendix B).

The Clinical Practice Unit (CPU) at Pace University is one of the country's first nurse-managed centers. The idea for the center started in 1975 in response to a recognized need for primary health care for ambulatory patients (Culbert-Hinthorn, et al, 1985). The Robert Wood Johnson Foundation provided the School of Nursing the funds to establish a health care facility which would meet the primary health care needs of the University and the needs of students and faculty for an appropriate clinical practice site.

The CPU at Pace is staffed with three ANA-certified, family nurse practitioners with graduate degrees and a physician consultant who is hired for four hours each week. Together, they developed written protocols for the diagnosis and management of minor acute illnesses, injuries, and stable chronic illnesses.

All nursing students and nursing school faculty practicing in the CPU follow these written protocols. The clinic is opened during the day throughout the year. The scope of services offered by the CPU is a reflection of the interests and the expertise of the nurses practicing there. Examples of services range from behavior modification programs for weight reduction to programs on human sexuality, alcohol and drug abuse, and other health promotion behaviors. The health care provided in the CPU is considered comprehensive. It is comprised of some curative care which is provided by nurses in collaboration with a physician. But most of the care provided is education and support to prevent recurrence of health problems and to promote positive health behaviors (op. cit.).

Another example of a nurse-managed clinic opened in September 1980 at the Comprehensive Health Social Services Clinic associated with Henry Ford Hospital. The Nurse-Managed Chronic Disease Clinic offers care to patients with high blood pressure, diabetes, pulmonary disease, and other chronic illnesses (Urban Health, 1980). The patients have chronic diseases which require long term attention but not necessarily frequent care by a physician. The purpose of the clinic is not to take patients away from the physician but to give the in-depth instruction that the doctor does not have the time to provide.

In addition to other cost benefits of a nurse administered unit, the job satisfaction of the nurses has been credited with job retention. The cost of recruiting, hiring, and training new staff members significantly increase the operating costs of a nursing budget (Hoffman, 1985). Wandelt and associates identified that the major reason nurses leave nursing is because work conditions interfere with the practice of professional nursing (Wandelt, et. al., 1981). The turnover rate for nurses working in NAUs is reported to be very low (Urban Health Care, 1981; Hall, 1975, & Braulick, 1983). An example of a highly satisfying work endeavor was reported by nurse managers working in a nurse managed multiple sclerosis clinic (Wedquist, 1984). Because of the unique practice setting, the nurse clinical specialists reported they experienced unique opportunities to practice nursing. Patients were reported to have played a pivotal part in the practice setting for these neurologically disabled individuals.

The health care literature is becoming replete with cost effective therapies. The economic viability of health care is a very critical issue as well as a preoccupation with warnings about simultaneously improving the quality of health care. The development of nurse administered units is one way of meeting the health needs of a portion of society. The entire health care system must be responsive to the needs of individuals. This responsiveness to the patient is probably the most cost effective

(- approach in the long run.

6. PLAN:

Location: The first Nurse Administered Unit at WRAMC would begin with the location of approximately twelve patient beds and the various designated classrooms, utility rooms, and offices to support the unit. Recognizing that bed space is at a premium at the medical center, present space would have to be reallocated to create the unit. Identification of sites which might be considered for the unit are located on ward 61, 62, or 63 (see Appendix C). The appendix shows how the proposed unit could be transposed onto the existing areas with little or no structural changes. No structural changes would be needed because the units were originally designed as patient care areas rather than for administrative occupants. Rooms are already equipped with bathrooms, tracts for hanging privacy curtains, supply cupboards, and surrounding rooms designed to be nursing stations, utility rooms, or pantries.

Staffing: The number and mix of staff are computed using staffing guides available to the Nurse Methods Analyst (Appendix D). Because of the need for the present staffing at the medical center, the nurses for the proposed unit would best be allocated from the Army Nurse Corps Career Activity Office. Job descriptions for the staff needed for the Nurse Administered Unit are included in (Appendix D). The job description of the staff are similar to those of nurses assigned to other Nurse Administered Units.

Impact on other services: A Nurse Administered Unit potentially impacts upon the Nutritional Care Directorate and may involve opening an unused pantry. Multidisciplinary conferences would routinely occur. Personnel from the unit would consult with other services such as Physical Therapy, Occupational Health, Nutritional Care Directorate, Enteral Stomal Therapy, Psychiatric Nurse Specialists, Social Service, Oncology Nurse Specialists, and Community Health Nursing. Consultation with these services would ensure that the specialty treatments would be prescribed while the nurses would ensure that the therapies are followed throughout the hospitalization.

Resources: Setting up the unit would require the standard as well as additional equipment needed in the rehabilitation of patients. Appendix E contains the list of equipment projected for the unit. Structural changes would not be required if the unit were selected from a site already designed to be a patient care area (See Appendix C). Activation of the Nurse Call System, alteration in directional signs, and telephone adjustments would be required. Equipment installation would be minimal with the exception of a whirlpool bath.

7. BIBLIOGRAPHY

1. Alfano, Genrose, ed. (1980). All-RN Nursing Staff. Wakefield, Massachusetts: Nursing Resources.
2. Braulick, Ruth A., Coronado, Jose R., Heil, Evelyn, Burt, Marguerite L., & Lutonsky, Roseann W. (1983) On the scene: Audie L. Murphy Memorial Veterans Hospital. Nursing Administration Quarterly, Spring, 15-45.
3. Coleman, John R., Dayani, Elizabeth C., and Simms, Elsie. (1984) Nursing careers in the emerging systems. Nursing Management, 15 (1), 19-27.
4. Cooperative Care: patient, partners, and professionals (NYU Medical Center). (1981) Geriatric Nursing, American Journal of Care for the Aging.
5. Culbert-Hinthorn, Pamela, Fiscella, Karin D., and Shortridge, Lillie M. (1985) A nurse-managed clinical practice unit: Part 1--the positives. Nursing & Health Care, 6 (2), 97-100.
6. Hall, Lydia E., Alfano, Genrose J., Rifkin, Harold, & Levine, Herbert S. (1975) Longitudinal effects of an experimental nursing process supported by Public Health Service Grant Number NU-00308, Division of Nursing (Final Report).
7. Hancock, Walton M., Flynn, Patricia L., DeRosa, Sharon, Walter, Paul F., and Conway, Candace (1984). A cost and staffing comparison of an all-RN staff and team nursing. Nursing Administration Quarterly, 45-55.
8. Hoffman, Frances M. (1985) Cost per RN hired. The Journal of Nursing Administration, 15, 27-29.
9. Lundeen, Sally P. (1985) Nurse-managed centers offer more to patients, nurses. The American Nurse, 17 (3), 3, 22.
10. Nelson, Dorothy. Nurse managed rehabilitation (1984). Nursing Management, 15 (3).
11. Nurse managed chronic disease clinic opened by Ford Hospital. (1980) Urban Health.
12. Savings report: shared care reduces acute-care costs. Fall (1979) Hosp. Manage. Quarterly.
13. Schussler, Theodore. (1984) Reducing hospital admissions from a skilled nursing home. Urban Health, 13 (7), 34-35.

14. Sheldon, Mark. (1984) Ethical issues in the cost-containment of modern medicine. Urban Health, 13, 25, 48.
15. Stanton, Marietta P. Patient and health education: Lessons from the marketplace. (1985) Nursing Management, 16 (4), 28-30.
16. Wahlquist, Glee I. (1984) Impact of a nurse managed clinic in multiple sclerosis. Journal of Neurosurgical Nursing, 16 (4), 193-196.
17. Walker, Duane D. (1983) The cost of nursing care in hospitals. The Journal of Nursing Administration, 13-18.
18. Wallace, Mary A. and Corey, Linda. (1983) The clinical specialist as manager: myth versus realities. The Journal of Nursing Administration, 13-15.
19. Wandelt, Mabel A., Pierce, Patricia M., and Widdowson, Robert R. (1981) Why nurses leave nursing and what can be done about it. American Journal of Nursing, 72-77.
20. Zauzmer, Debra. (1985) VA's geriatric units prolong initial LOS for long-term payoff. (News) Health Care Systems, 3, 50.

APPENDIX A

Center for Nursing Therapy
Audie Murphy Memorial
Veterans' Hospital
San Antonio, Texas 78284

ADMINISTRATIVE POLICY
Nurse Administered Units
Approved by the Board of Directors
Date: 11-1-70

POLICY

MEMO NUMBER 10. 11-1-70

Page 1 of 1

NURSE ADMINISTERED UNITS

1. PURPOSE: There are two types of Nurse Administered Units: (1) The Nurse Administered Evaluation Unit is an in-bed area designated for the care of patients on a short term basis, who can benefit primarily from nursing care services; (2) The Nurse Administered Center for Nursing Therapy is an in-bed area designed for the care of patients whose condition has stabilized. The primary focus of this unit is to encourage and assist the patient in attaining his maximum level of independence. Patients on these units do not require daily physician attention.

2. POLICY: The role of the Nurse Administered Units is unique in its ability to provide individualized nursing care to those patients whose health status is under the care of a physician but do not require close observation by the medical staff. Patients admitted to the Nurse Administered Evaluation Unit will be primarily self care, including medications. Those patients admitted to the Center for Nursing Therapy may be self care but will include those patients which require partial or total assistance with their care, including medications.

3. PROCEDURES:

a. Admission criteria for the Nurse Administered Evaluation Unit:

(1) Patients must be accepted through evaluation by the Nurse Administrator of the unit or her designee.

(2) Outpatients scheduled for a series of evaluation studies who live outside the city or have transportation difficulties.

(3) Outpatients scheduled for radiological or laboratory tests which require special preparation or exact specimen collecting procedure to ensure valid test result: Example-barium enema, gall bladder series, 5-hour glucose tolerance test, 24 hour urine specimen test, etc.

(4) Outpatients and transferred patients coming in for scheduled clinic appointments who, because of unusual circumstances, are not seen by a physician, can remain overnight or until a series of appointments can be completed: Example-Neurology or Neurosurgery appointment.

(5) Dental patients living at a distance from the hospital who require intensive, short-term treatment.

POLICY
MEMORANDUM NO. 11-84

(6) Patients with medical problems who live at a distance and require overnight observation.

(7) Ambulatory diabetic patients who are stabilized on medications, but who can benefit from further individualized instruction and evaluation of teaching.

b. Admission and transfer criteria for the Center for Nursing Therapy in addition to those listed above:

(1) There is evidence that the patient and/or family require instruction and reinforcement in self-care activities to increase the level of independence.

(2) Patients require additional instructions regarding activities of daily living as related to their health problems, i.e., diabetes, ostomies, dressing changes, chronic lung disease, cardiac rehabilitation, self-medication.

(3) Definite post-hospital plans have been made for the patient.

(4) A completed discharge summary including current medical status and treatment plan has been written by the physician prior to transfer from inpatient service.

(5) Orders and prescriptions for medications and/or supplies required, if any, have been written.

(6) Selected inpatients awaiting Nursing Home Placement will be considered under the following conditions:

(a) Patient's record must reflect documentation from the social worker regarding specific plans, including family awareness of the plans and their participation in the development.

(b) The necessary forms have been completed. These include:

1. VA Form 1204 (Nursing Care Referral).
2. Physician's Discharge Summary.
3. Prescriptions written.

c. There must be evidence that required prosthetic devices have been prescribed by the physician and ordered by Prosthetics. (These will be held in Prosthetic Service until the patient is discharged from the hospital.)

d. Physician's orders will be written on VA Form 10-1000A (Abbreviated Medical Record) or the doctor's order sheet (10-1158). Additional medications, if required, will be written on a prescription form, VA 10-2577D and obtained from the Hospital Pharmacy.

e. Discharge Process:

(1) On an admission of 48 hours or less, the nurse will write a

POLICY

MEMORANDUM NO. 11-77-10

Subject: Hospitalization of Patients with VA Form 10-1000.

(2) Hospitalization over 48 hours:

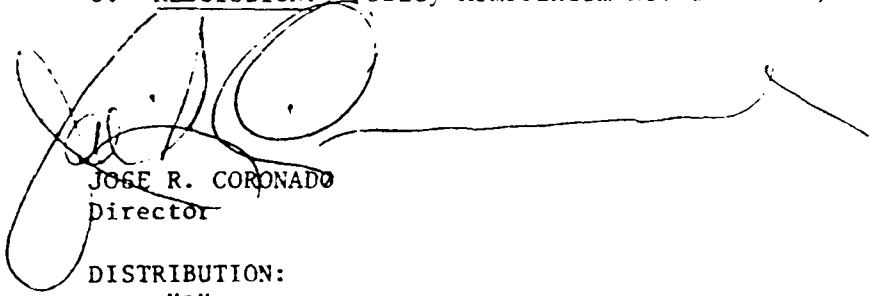
(a) Direct admissions to the NAU's with hospitalization over 48 hours require a discharge summary, VA Form 10-1000, to be dictated by the nurses. This summary is forwarded to the appropriate Chief of Service or designee.

(b) Transfers from other units require a discharge summary, VA Form 10-1000, to be dictated by the primary physician prior to transfer. An addendum will be dictated or written by the NAU nurse.

4. RESPONSIBILITY: Functions of the nurse include utilization of the nursing process to determine patient health care needs, changes in health status, and readiness for discharge. The nurse, as primary provider of care, collaborates with the physician and other members of the health care team in providing expeditious coordination of services. Determination regarding the patient's program of care and discharge will be coordinated with the physician responsible for patient care. Any health problem will be evaluated by the service responsible for the scheduled clinic appointment. In the event the medical record or originating service is not available and the patient is on "Consultation" from a satellite clinic without medical records, the patient will be evaluated in Triage to identify medical coverage prior to admission.

5. REFERENCES: None.

6. RESCISSION: Policy Memorandum No. 11-77-10, dated November 23, 1977.


JOSE R. CORONADO
Director

DISTRIBUTION:
"B"

AUDIE L. MURPHY
MEMORIAL VETERANS HOSPITAL
SAN ANTONIO, TEXAS

NURSING SERVICE MEMO 83-6
January 17, 1983

TO: All Nursing Personnel
FROM: Chief, Nursing Service
SUBJECT: Responsibilities of the Nurse Administrator

1. PURPOSE: To provide information regarding the functions and responsibilities of the Nurse Administrator assigned to Nurse Administered Units.

2. POLICY: The Nurse Administrator is responsible to the Associate Chief, Nursing Service for providing health care to veteran patients in consultation with the Department of Medicine. The Nurse Administrator functions within professional and legally established parameters, and carries out the following functions:

A. Delivers appropriate comprehensive care based on the concept of primary nursing.

B. Determines if the patient is medically eligible for admission to the unit.

C. Completes an on-going patient assessment to determine changes in health status, the need for health teaching, the need for expansion of care and readiness for discharge.

D. Authorizes the patient to remain on the unit over 72 hours if the patient has not completed his clinic appointments or is awaiting diagnostic data. The Nurse Administrator or designee completes the history and physical examination prior to the patient's discharge and dictates a concise relevant narrative summary. The summary is forwarded to the appropriate Chief of Service, i.e., Medical, Surgical, Psychiatry, Dental, Health Maintenance Clinic, Rehab Medicine or Staff Physician member for his signature.

E. On an admission of a patient hospitalized for 72 hours or less, the Nurse Administrator or designee completes a brief, relevant medical summary on an abbreviated Medical Record (VA Form 10-1000a, a hospital summary of this type does not require the approval signature of a physician).

F. Initiates physician and nurse consultations as a need is determined for individual patients.

G. Provides leadership for nursing personnel on all preparational levels and provides assistance in planning, implementing, supervising and evaluating quality nursing care.

H. Serves as a consultant to other nursing units in assessing patient's readiness for self-care and for requirements for assistive devices.

Nursing Service Memorandum 83-6

I. Provides on-going inservice for educational experiences at the unit level. Teaches staff nurses the skills needed for physical assessment, interviewing, history taking, and dictating medical discharge summaries.

J. Collaborates with Nursing Service and education to incorporate current nursing trends, policies and skills into nursing practice for improvement of veteran patients.

K. Coordinates patient education endeavors involving other health disciplines. Patient teaching focuses attainment of desirable health status and on health maintenance.

L. Coordinates effective use of personnel, equipment, facilities, and services so as to provide appropriate continuity for the patient and his family during various phases of diagnostic studies.

M. Provides adequate nursing coverage for patient care and for efficient operation of the unit on a 24-hour basis.

N. Determines patient's need for and initiates standard screening tests, i.e., for diabetes mellitus, hypertension, etc.

3. RESCISSION: Nursing Service Memorandum 81-34, dated August 20, 1981.

Marguerite L. Burt

MARGUERITE L. BURT, R.N.
Chief, Nursing Service

AUDIE L. MURPHY
MEMORIAL VETERANS HOSPITAL
SAN ANTONIO, TEXAS

NURSING SERVICE MEMO 84-4
February 10, 1984

TO: All Nursing Personnel

FROM: Chief, Nursing Service

SUBJECT: A Guide to Promote the Development of Nurses to Function in the Nurse Administered Units (NAUs).

1. PURPOSE: To provide a systematic approach for interested candidates to obtain fundamental knowledge and skills that will prepare them to function as nurses in the Nurse Administered Unit.

2. POLICY: Selection into the NAU setting will ultimately depend upon unit need and personal qualifications.

3. EDUCATION: BSN preferable or comparable practice.

4. PAST NURSING EXPERIENCE:

- A. One year medical/surgical or psychiatric experience.
- B. Experience in public health or ambulatory care is preferable.
- C. One year VA nursing experience preferable.

5. FUNCTIONS/ACTIVITIES

SUGGESTED CLINICAL EXPERIENCE

I. Data collection, assessment, planning, implementing and evaluating of various health and disease states with varying levels of activity.

I. (a) Promotes, supports and provides primary nursing care.

(b) Demonstrates clinical competence in caring for patients with a varied spectrum of diseases such as:

- (1) Diabetes
- (2) Hypertension
- (3) Cardiovascular Diseases
- (4) Cancer Therapy
- (5) Pulmonary Diseases
- (6) Rehabilitation Needs

- a. medical
- b. surgical

II. Functions in expanded role within nursing, utilizing autonomy, self-direction and accountability within a limited physician directed setting.


II. (a) Verbalizes knowledge of independent nursing roles.

(b) Practices leadership skills in directing and implementing patient care.

NURSING SERVICE MEMORANDUM 84-4
February 10, 1984

III. Promotes and participates in the health teaching of patients, family, staff, and students.

IV. Writes/dictates medical discharge summaries, initiates referrals and consults which are reported concisely, systematically and accurately.


MARGUERITE L. BURT, RN
Chief, Nursing Service

- (c) Exhibits skills in problem-solving and decision-making.
- (d) Possesses ability to accurately evaluate levels of wellness/illness in acute and chronic phases.
- (e) Possesses knowledge of available support services and resources.
- (f) Recognizes need for and initiates intervention with allied health services.
- (g) Utilizes effective communication skills.

- III. (a) Using self-care concepts, develops and implements protocol for individual patient and family health teaching needs, realizing the need for mutual goal setting.
- (b) Demonstrates ability to teach at patients' and family's level of comprehension.
- (c) Possesses knowledge of a variety of teaching techniques applicable to planning, implementing and evaluating patient learning needs.
- (d) Identifies personal and peer group learning needs and promotes skill and theory proficiency through:
- (1) Unit inservice
 - (2) Unit Orientation
 - (3) Continuing Education

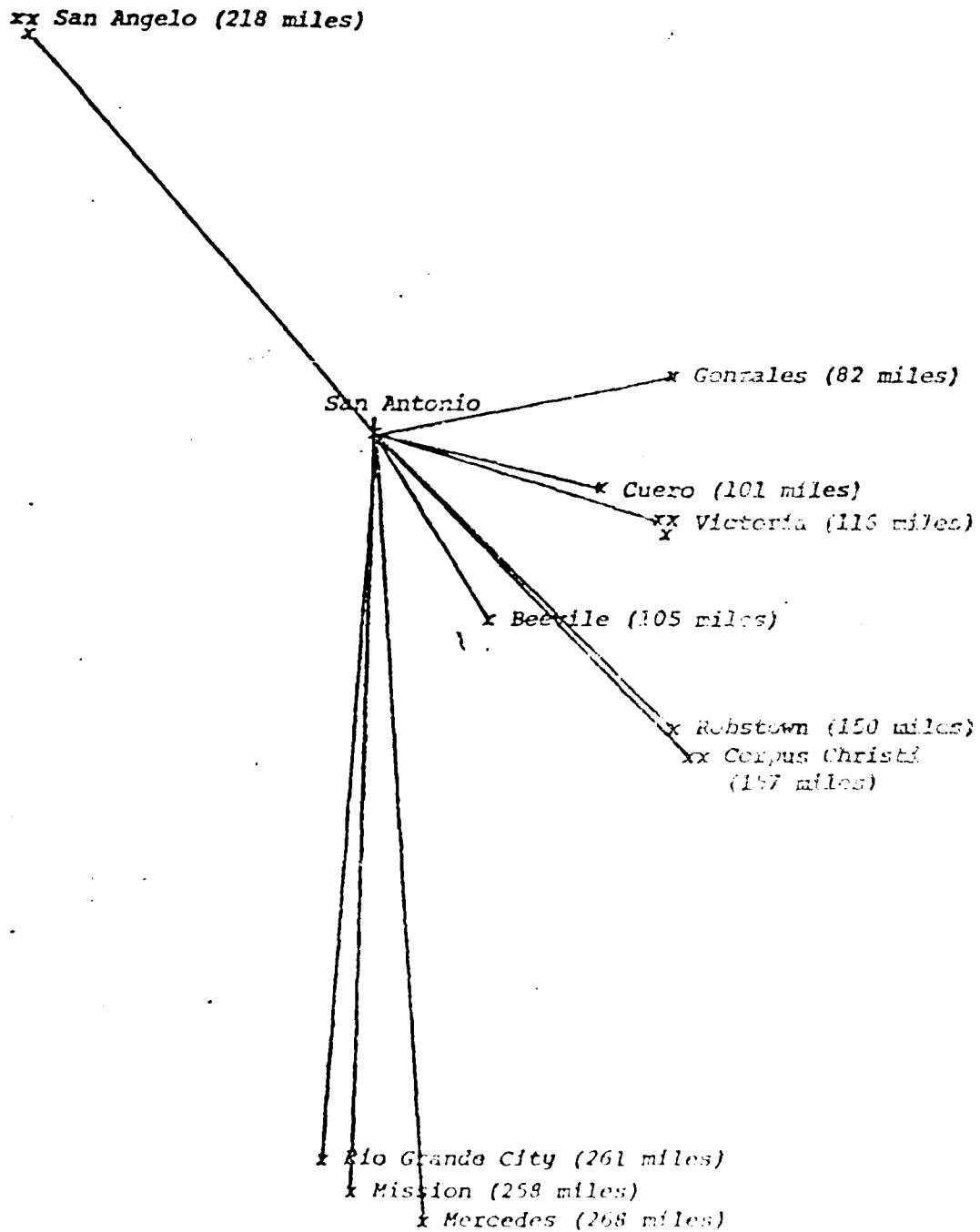
- IV. (a) Accurately documents in the progress notes.
- (b) Initiates consults and referrals to multidiscipline specialties.
- (c) Accurately completes the nursing discharge/transfer summary.

Dr. del

NAU PATIENT PROFILE

1. On the average, four 1-day-admission patients per day are admitted to our NAU.
2. One-day-admission patients will usually have stayed overnight.
3. The 1-day inpatient will have traveled a great distance to come to Audie Murphy VA Medical Center. 95% live outside a 60-mile radius from San Antonio (see Map).
4. Many patients will have multiple consultations during their stay. 42% of the 1-day patients will see two or more different specialties.
5. Because of special preparations, consultations on two days, or special precautions, treatment on an outpatient basis is often not feasible for the NAU, 24-hour patient.

RESIDENTS OF ALL ONE DAY ADMISSION PATIENTS
ADMITTED JANUARY 1-11, 1940



ONE-DAY ADMISSIONS
(Including Hemodialysis)

<u>PERIOD</u>	<u>DISCHARGES</u>	<u>%</u> <u>1-DAY ADMISSIONS</u>
October 78	<u>one-day</u> 512	<u>total</u> 1422- 36.0%
November 78	472	1359 34.7%
December 78	504	1384 36.4%
TOTAL	1488	4165 35.7%

ONE-DAY ADMISSIONS
(Excluding Hemodialysis)

<u>PERIOD</u>	<u>DISCHARGES</u>					<u>TOTAL</u>	<u>1-DAY ADMISSIONS</u>
	NAU	MED.	RMS	SURG.	PSY.		
Oct. 78	127	42	0	29	7	205	18.4%
Total October discharges						1,115	
Nov. 78	139	30	0	12	5	186	17.3%
Total November discharges						1,073	
Dec. 78	107	36	0	46	5	194	18.1%
Total December discharges						1,074	
TOTAL	373	108	0	87	17	585 3,262	17.9%

VETERANS ADMINISTRATION HOSPITAL

SAN ANTONIO, TEXAS

POLICY
MEMORANDUM NO. 119-82-10

May 6, 1982

SELF ADMINISTRATION OF MEDICATIONS

1. PURPOSE: To establish policy regarding the self administration of medications by hospitalized patients.

2. DEFINITION: Self administration is the procedure which permits a specific patient to administer to himself those medications authorized for his treatment by a responsible physician.

3. POLICY: Under the written orders of a responsible physician, patients who are determined to be self care may self administer medications.

4. PROCEDURES:

a. The prescribing practitioner will authorize self administration of medications on either the Doctor's Orders (VA Form 10-1153) or the Clinical Record of Self Administered Medication (SF 507, OP 118-76-5). The physician must sign one of the forms to allow self administration.

b. The Primary Nurse will implement the decision when it is appropriate for the patient to begin self administration. Nursing personnel will provide the patient with in-depth instruction on medication actions, side effects, frequency of administration and method of recording before initiating the self medication regime.

c. All medication provided by the Pharmacy will be in unit-dose form except for those patients admitted to the Nursing Administered Units (NAU). Following authorization by the prescribing practitioner, patients admitted to the NAUs may retain medication brought in to the hospital for their bedside use. On nursing units other than the NAUs, the patients will take medications from the 24-hour supply in their individual cassettes. The cassettes will be stored at bedside.

d. The patient will record all doses, dates and times of administration. Upon discharge, this record will be placed in the patient's clinical chart. Medications brought into the NAU units by patients will accompany the patients home upon discharge. In all other areas, the medication will be returned to the medication cart upon discharge.

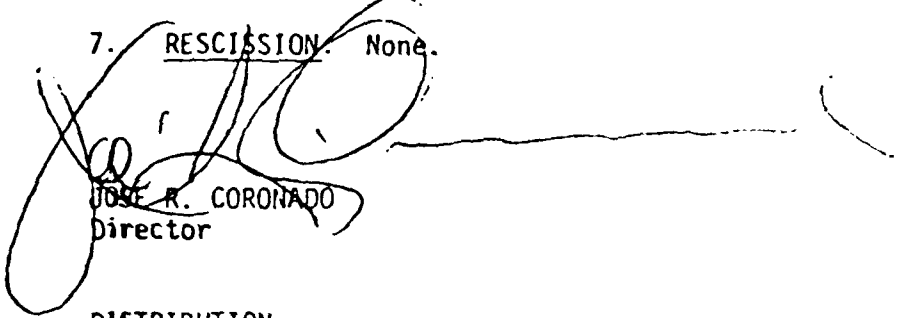
POLICY

MEMORANDUM NO. 119-82-10

5. RESPONSIBILITIES: The prescribing practitioner is responsible for authorizing self administration of medication. The primary nurse is responsible for monitoring all aspects of self administration. Pharmacy Service is responsible for providing assistance to the professional staff.

6. REFERENCES: VA Manual M-2, Part VII, Change 3, Chapter 1, paragraph 1.01d and Chapter 3, paragraph 3.01d.

7. RESCISSION: None.



JOSE R. CORONADO
Director

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VETERANS ADMINISTRATION MEDICAL CENTER
SAN ANTONIO, TEXAS

Survey of One and Two Day Admissions to NAU

March, 1979

Investigators: Margaret deWever, ACNSR
Sondra Marcum, Nurse Administrator
Vivian Yancey, Nurse Administrator

Purposes: To determine the nursing needs during hospitalization of patients admitted to the Nurse Administered Units during February 1979 and then discharged after one or two days of hospitalization.

To determine service connected status, distance traveled to reach the medical center, and number and type of clinics attended among patients who were admitted to the Nurse Administered Units during February 1979 and then discharged after one or two days of hospitalization.

Definitions: Each patient in the sample was categorized as to nursing needs as follows:

"PREPARATION" patients were those patients who needed assistance in following instructions for special procedures; and thus, nursing care during hospitalization obviated the need for repeated procedures because of inadequate preparation. Included in this category were patients needing preparation for a barium enema, a gallbladder series, an intravenous pyelogram, a sonogram, etc.

"OBSERVATION" patients were those patients who needed skilled nursing observation. Included in this category were patients who needed observation following such procedures as endoscopy, bronchoscopy, electro-shock therapy, nerve block for pain, etc. Also included were patients who needed skilled nursing observation because of their medical status: patients with a potentially harmful diastolic blood pressure; patients who had sustained head trauma; patients with seizures; patients whose self-reported symptoms needed to be confirmed; etc.

Categorization of patients as to needs was based mainly on documentation in the patients' records; and thus, the number of patients categorized as SELF-CARE might have been inflated and the number of patients placed in one or more of the other categories might have been deflated.

**Results,
one day
admissions:**

Among the 141 patients admitted for one day, 67 patients or 47.5% were in need of skilled nursing care. These patients included 11 who needed preparation, 34 who needed observation, 21 who needed help with activities of daily living, and 1 who was admitted for adjustment of his medical regime. (See Table 1.) There were also 74 self-care patients, 30 of whom were service connected.

Among the 30 service connected self-care patients, the distance traveled from home to the medical center ranged from 34 miles (Uvalde, Texas) to 282 miles (Brownsville, Texas) with a median distance traveled of 157 miles. (See Table 2.) Among these 30 patients, 25 had one clinic appointment, 3 had two clinic appointments, 1 had appointments for a clinic and for a CAT scan, and 1 patient was admitted overnight because of transportation problems. (See Table 3.)

Among the 44 non-service connected self-care patients, the distance traveled from home to the medical center ranged from 35 miles (New Braunfels, Texas) to 730 miles (Pensacola, Florida) with a median distance traveled of 167 miles. (See Table 2.) Among these 44 patients, 40 had one clinic appointment, 3 had two clinic appointments, and 1 had three clinic appointments. (See Table 3.)

Results,
two day
admissions:

Among the 74 patients admitted for two days, 50 patients or 67.6% were in need of skilled nursing care. These patients included 12 who needed preparation, 25 who needed observation, 12 who needed help with activities of daily living, and 1 who was admitted for adjustment of his medical regime. (See Table 1.) There were also 24 self-care patients, 6 of whom were service connected.

Among the 6 service connected self-care patients, the distance traveled from home to the medical center ranged from 98 miles (George West, Texas) to 302 miles (Big Springs, Texas) with a median distance traveled of 264 miles. (See Table 2.) Among these 6 patients, 3 had one clinic appointment, and 3 had two clinic appointments. (See Table 3.)

Among the 18 non-service connected self-care patients, the distance traveled from home to the medical center ranged from 82 miles (Gonzales, Texas) to 784 miles (Guatemala City, Mexico) with a median distance traveled of 251 miles. (See Table 2.) Among these 18 patients, 10 had one clinic appointment, 5 had two clinic appointments, 1 had appointments for a clinic and for a bone scan, and 2 had three clinic appointments.

Margaret deWever

Margaret deWever, RN, EDD

Table 1. Number of NAU patients admitted for one and two days, numbers and percent of patients who needed preparation for special procedures (PREPARATION), skilled nursing observation (OBSERVATION), assistance with activities of daily living (ADL), assessment for altered medical regime (ADJUSTMENT), and number of service connected and non-service connected patients who were capable of self-care (SELF-CARE).

Needs	Admissions			
	One day		Two day	
	#	%	#	%
PREPARATION	11	7.3	12	16.2
OBSERVATION	34	24.1	25	33.3
ADL	21	14.9	12	16.2
ADJUSTMENT	1	0.7	1	1.4
SC SELF-CARE	30	21.3	6	8.1
N/SC SELF-CARE	44	31.2	18	24.3
Totals	141	100.0	74	100.0

Table 2. Distances traveled from home to medical center by service connected and non-service connected, SELF-CARE, NAV patients admitted for one and two days.

Patients	Miles									
	over 700	300 - 349	250 - 299	200 - 249	150 - 199	100 - 149	50 - 99	under 50		
One day admissions, SC number percent cumulative percent	- - -	- - -	7 23.3 23.3	5 16.7 40.0	11 36.7 76.7	6 20.0 96.7	1 3.3 100.0	- - -		
One day admissions, N/SC number percent cumulative percent	1 2.3 2.3	- - -	12 27.3 29.6	3 6.8 36.4	14 31.8 68.2	11 25.0 93.2	2 4.5 97.7	1 2.3 100.0		
Two day admissions, SC number percent cumulative percent	- - -	1 16.7 16.7	3 50.0 66.7	- - -	1 16.7 83.3	- - -	1 16.7 100.0	- - -		
Two day admissions, N/SC number percent cumulative percent	2 11.1 11.1	- - -	8 44.4 55.5	2 11.1 66.7	4 22.2 88.9	1 5.6 94.4	1 5.6 100.0	- - -		

Table 3. Numbers of service connected and non-service connected, SELF-CARE, NAU patients attending each clinic.

Clinics	One day admissions		Two day admissions	
	SC	N/SC	SC	N/SC
Anesthesia pain	-	-	-	1 ¹⁵
Anticoagulant	-	-	-	1 ¹²
Audiology	-	-	-	1 ^{13,14}
Cardiology	-	1	-	1 ¹⁶
Dermatology	2 ³	-	-	-
EMG	-	1	-	-
Endocrine	-	2	-	-
ENT	2 ³	3 ^{5,6}	2	3 ^{13,14}
Eye	1 ¹	-	2 ¹⁰	2
G.I.	1 ²	2 ⁷	-	1 ¹⁶
G.U.	-	1	-	2 ¹²
Gyn	-	1	-	-
Health maintenance	4	14 ^{4,7}	1 ⁶	1
Hematology	-	2	-	2
Hypertension	1	-	-	-
Medicine	2	2	1 ⁹	-
Neurology	4	3	1 ¹⁰	-
Nuclear medicine	-	1	-	-
Nutrition	1 ²	1 ⁵	-	1 ¹¹
Oncology	1	1	-	1
Orthopedic	13 ¹	5	-	2 ^{14,15}
Psychiatry	1	1	1 ³	-
Radiation therapy	-	-	-	1
Renal	-	2 ⁶	-	-
Rehabilitation	-	2 ^{4,7}	-	2 ^{11,15}
Surgery general	3	3	1 ⁹	2
Thoracic	-	1	-	-

Note: Exponential numbers indicate a patient who attended more than one clinic.

APPENDIX B

Cooperative Care

N. Y. University Medical Center,



560 First Avenue, New York, NY 10016
Cable Address: NYUMEDIC

(212) 340- 5507

April 1, 1985

LTC Susan McMarlin
Nursing Research Service
Walter Reed Army Medical Center
Washington, D.C. 20307-5001

Dear LTC McMarlin:

Enclosed are the materials that you requested concerning Cooperative Care. I do apologize for "dropping the ball" and for the fact that you had to call me a second time. Please note that the Assistant Director of Nursing in charge of the Cooperative Care Center selected some of our policies that she thought would be particularly germane to your project.

Please do not hesitate to call if there is anything further that you require. As I told you on the phone, a visit to the unit would probably be most beneficial if you could arrange that.

Sincerely,

A handwritten signature in cursive script, reading "Margaret L. McClure".

Margaret L. McClure, R.N., Ed.D., FAAN
Executive Director of Nursing

MLM:gr
Encl.

NYU Medical Center
School of Medicine
Post-Graduate Medical School
University Hospital
Institute of Rehabilitation Medicine

B-2

New York University
A private university in the public service

THERAPEUTIC CENTER

OBSERVATION UNIT SCHEDULING GUIDELINES

Patients undergoing an invasive procedure as part of their Cooperative Care admission require a period of observation immediately following that procedure. This monitoring will be provided in the Therapeutic Center's Observation Unit, located on the 14th floor of Cooperative Care. The Observation Unit consists of six beds, which are booked for use from 8 a.m. to 6:30 p.m., Monday-Friday.

Attached is a list of common procedures for which patients enter the Cooperative Care Unit. Observation Unit time for these procedures must be arranged before the reservation for admission can be accepted. The length of time each patient undergoing a specific procedure will be observed is also provided. These lengths of time are part of established Cooperative Care protocol and cannot be shortened at the time admission booking without the approval of clinical leadership.

Admission for elective blood transfusion is not booked into the Observation Unit. The Attending will make arrangements with the Blood Bank for transfusion in the main wing of University Hospital prior to scheduling the patient for admission to Cooperative Care.

PROCEDURES CANNOT BE SCHEDULED FOR THE DATE OF ADMISSION

In cases where some doubt exists about the need for Observation Unit time, clinical leadership is to be consulted before the reservation is accepted. Reservations involving the use of the main operating rooms, as well as bronchoscopic procedures to be done in the Therapeutic Center, are to automatically be referred to clinical leadership (see Operating Room policy attached).

Cooperative Care policy states that a Care Partner must be with the patient for 24 hours the day of any one of the attached listed procedures. The Care Partner will be expected to play a part in the patient's care while in the Observation Unit and must be available to the patient and Cooperative Care personnel.

PROCEDURE

LENGTH OF
OBSERVATION UNIT STAY

ANTICIPATED RETURN
TO OBSERVATION UNIT

COMMENTS

Liver Biopsy	6 hours	-----	8 a.m. procedure begins in Observation Unit
Cardiac Cath #1	4 "	11 a.m.	Maximum of four (4)
Cardiac Cath #2	4 "	Noon	Cath patients in one
Cardiac Cath #3	4 "	2 p.m.	day is in effect
Cardiac Cath #4	4 "	2 p.m.	
Adriamycin Infusion	6 "	-----	Via femoral catheter; 8 a.m. procedure begins in Observa. Rm. other than Adriamycin
Chemotherapy	Hours vary; will be specified according to drugs planned; doctor will provide information at time of booking.		
Angiography	4 hours	3 hrs. p start time	approximate schedule available at time of booking
Cystoscopy/TURBT	3 "	2 hrs. p start time	approximate schedule available at time of booking
Bronchoscopy	3 "	2 hrs. p start time	actual schedule available at time of booking
Myelography	6 "	3 hrs. p start time	approximate schedule available at time of booking
ERCP	4 "	2 hrs. p start time	actual schedule available at time of booking
Renal Biopsy	4 "	2 hrs. p start time	scheduled time of procedure available at time of booking
Endoscopy	4 "	1 hr. p start time	includes gastroscopy, colonoscopy and sigmoidoscopy

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NEW YORK UNIVERSITY MEDICAL CENTER

Interoffice Communication

May, 1984

The following orders may be followed by the Cooperative Care staff unless countermanding orders are received regarding specific patients.

1. Activity ad lib.
2. Diet to be determined by Nutritionist, including nutritional supplements as needed.
3. Medications used prior to transfer from University Hospital are to continue.
4. Medications used prior to direct admission to the Cooperative Care Center are to be continued, at the discretion of the nursing staff.
5. Substitution of formulary drugs for similar non-formulary drugs is authorized.

6. Stool softeners may be used as needed:

Colace 100 mgm po TID.

7. Cathartics may be used as needed:

Milk of Magnesia 30 ml. po prn. except following gastrointestinal surgery or if renal insufficiency is present (BUN over 40, Creatinine over 2.5).

8. Mild analgesics may be used for headache or pain:

Acetaminophen 650 mg po Q 4 hr prn.

9. Antacids may be used for heartburn or dyspepsia:

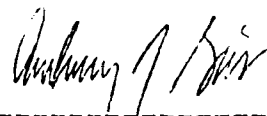
Gelusil 30 ml. po QID prn or Aluminum hydroxide gel 30 ml. po QID prn. In the presence of renal insufficiency (BUN over 40, Creatinine over 2.5) or diarrhea, magnesium-containing antacids should be avoided, but aluminum hydroxide gel may be used.

Codeine may be used.

Codeine (bromophen) 15 mg po QID prn sleep.

11. Robitussin may be used for minor cough.

12. Standard University Hospital preparations are to be used prior to procedures, including radiologic procedures, in the absence of other specific orders. Standard post-barium cleanout is also authorized (Milk of Magnesia 60 ml po).
13. Kaopectate may be used for diarrhea, 30 ml po QID prn.
14. 100 ml of Dextrose 5% in water (DSW) will be considered the fluid for administration of intravenous medication in the absence of a specific order. An exception will be made for (a) drugs incompatible with intravenous dextrose, such as dilantin, and (b) patients with diabetes in whom the glucose load is considered too great. 100 ml of normal saline may be substituted in these patients.



Anthony J. Grieco, M.D.
Medical Director

AJG/dd

NEW YORK UNIVERSITY MEDICAL CENTER
COOPERATIVE CARE

NURSING DEPARTMENT

MEDICATION CHARTING

FOR PATIENTS NOT ON SAM

1. Each nurse is responsible for charting meds administered on his/her shift.
2. Each nurse for each shift is responsible for making his/her own assessment as to whether the patient is responsible enough to take medications poured by the nurse and labeled with given time or if the patient requires a phone call to verify that they took the medication.
3. For any medications due between 12 midnight and 8 a.m., the patient must have a wake-up call or appointment to be sure that patient take the medication.
4. Medications can only be given through the next scheduled nursing contact.
5. The nurse making the next contact is responsible for verifying that the patient did, in fact, take the medications that had been poured and labeled with the given time by the nurse on the previous shift.
6. The nurse on the following shift is also responsible for maintaining the audit documents regarding the above.
7. If the patient did not take the poured and labeled medications, the nurse on the following shift must enter chart error on H.I.S., make the appropriate chart entry and explain the entry in the patient care notes.

FOR PATIENTS ON SAM

1. 8 a.m.-8 p.m. nurses will verify via patient contact and chart, all medications taken from 12:01 a.m.-8 p.m.
2. 8 a.m.-4:30 p.m. nurses will verify via patient contact and chart, all medications taken from 12:01 a.m.-4 p.m.
3. 8 p.m.-8 a.m. nurses will verify via patient contact and chart, all medications taken from 8:01 p.m.-Midnight.
4. 4 p.m.-12 Midnight nurses will verify via patient contact and chart, all medications taken from 4:01 p.m.-12 Midnight.
5. When a patient is put on SAM, nurses must document in nursing notes that patient is knowledgeable and capable of being put on SAM. Nurses must also put date of SAM entry into patient care worksheet.
6. Patient must be evaluated at each nurses appointment or contact (i.e. phone) for SAM accuracy (i.e. checking blue sheet, vials of medications, etc.).
7. Every patient admitted to Cooperative Care must be given a blue self-medication sheet, list of medications and a schedule of medication administration for each medication. If needed, are ordered at the time of admission. The patient, or nurse, give the patient a blank self-medication sheet to keep in his patient folder and present to the next appointment. All patients should be instructed to bring all medication bottles and self-medication schedules to all nurse contacts.

STAT/PRN/HS MEDICATIONS

1. Stat medications are to be charted immediately upon administration by the nurse who gives the medication.
2. PRN/HS medications will be charted by the nurse that actually gives the patient the drug in the following way:
 - a. chart in H.I.S. "given for SAM at ____ (time the patient plans to take the medication).
3. The nurse on the day shift (either 8 a.m.-8 p.m. or 8 a.m.-4:30 p.m.) will verify if the patient took the medication and will chart this in the nursing notes along with the patient's response to the drug.

NEW YORK UNIVERSITY MEDICAL CENTER
COOPERATIVE CARE CENTER

SELF-ADMINISTRATION OF MEDICATION (SAM) EDUCATION

GOAL: By the time of discharge from Cooperative Care, the patient and/or care partner will be capable of and demonstrating self-administration of medication.

EDUCATION OBJECTIVE:

By completion of teaching, the patient and/or care partner will be able to verbalize accurately for each medication he will be self-administering:

1. name of medication
2. purpose
3. dose or some form of accurate identification
4. frequency of administration
5. any significant side effects
6. when to notify the nurse in Cooperative Care or the doctor/pharmacist at home
7. any special precautions when taking the medications including food or drug interaction.

METHODOLOGY:

A. TRANSFERS:

1. Preparation

On admission to Cooperative Care, the Education Center nurse will:

- a. review doctor's order sheet to identify prescribed medications for that patient
- b. pull information sheets for all medications prescribed

2. Self-Administration of Medication Orientation

As part of the orientation process, the Nurse Educator will conduct an orientation to SAM that includes:

- a. discussing educational philosophy of Cooperative Care (i.e. provide patient with varied professional assistance for patient to learn about his own health care maintenance.
- b. at Cooperative Care we will teach the patient about their medications and how to take them during their stay where professional are available to answer questions.
- c. a description of the general format of the medication sheet will be given.

d. the plan for the teaching process:

1. the patient will get an information sheet for each medication
2. the patient is to read/study the sheets overnight
3. the patient should bring the information sheets and medication schedule to the SAM counselling session which will be scheduled as soon as possible.
This session can be with either a Pharmacist or a Nurse Clinician in the Therapeutic Center. All patients meeting the following criteria will have a consult with a pharmacist scheduled.
 - a. if on any medication prescribed differently from usual.
 - b. if on three (3) or more medications (non prn)
 - c. if on coumadin, steroids, cardiac medications, antibiotics or medication for high blood pressure
 - d. if any scheduling/interaction conflicts with medications
 - e. if on medications for which there are no information sheets
 - f. if on hypoglycemic agents
 - g. if on prn medications that have special precautions or side effects that are to be self-administered
 - h. if the patient has renal or hepatic impairment and is pre-scribed medications
 - i. the Care Partner may have to be scheduled with the patient or instead of the patient if the patient is to be discharged on medications and if the patient has difficulty with self-administration of medication
 - j. if recommended for consult by nurse educator or nurse clinician.
4. If patient meets above criteria and is scheduled for pharmacist consult, the nurse clinician should emphasize the need to attend the consult before patient can self-administrate his medications. When possible, the nurse clinician can assist patient in developing schedule.
5. patients not meeting above criteria can be assessed for SAM by the nurse clinician.

3. Individualized Self-Administration of Medication Counseling Session

When the patient arrives for the counselling appointment, the Pharmacist will:

- a. review each medication utilizing the information sheet emphasizing essential information
- b. ask patient to verbalize pertinent information about each medication
- c. make a medication appointment sheet

4. Follow-through

- a. after the pharmacist or nurse clinician has completed the SAM counselling session, the pharmacist will give the patient a separate card for each medication and a medication cassette. This should be done to ensure the patient's ability to self-medicate.

- b. Pharmacist will document above results on patients' chart on Education Care plan
- c. Nurse Clinician will review with patient each medication assessing adequacy of patient's comprehension. She will then place patient in one of three categories:
 1. Patient can self-administer the medications reviewed; the Nurse Clinician will fill out schedule with patient reinforcing need to schedule according to medication administrative requirements and number of doses each day.
 2. Patient needs further review or reinforcement:
 - a. more review or teaching
 - b. telephone reminder at times of administration
 3. patient is unable to self-administer medications at this time.
- d. Nurse Clinician will determine from above categorization whether patient is to start SAM immediately. If so, Nurse Clinician gives the patient the medications, reviews each medication by name and instructions on the label, directs him to check off on his/her schedule each time he takes his medications, and INSTRUCTS HIM TO BRING THAT SCHEDULE TO HIS NURSE CLINICIAN CONTACT EVERY DAY.
- e. The Nurse Clinician will document the above on the patients chart by writing SELF and initialling the Medication Sheet each shift.
- f. The Nurse Clinician will strive to develop level of SAM competency during Cooperative Care stay for those patients who are unable to self-administer medications initially.

5. New Medication Orders

- a. Nurse Clinician will either:
 1. Call the Education Center to have the patient scheduled for individualized counselling session with the Pharmacist to review the medication change and to revise the patient medication schedule accordingly. This can be done by phone consult unless new medication has special or complicated information (e.g. steroids, coumadin, etc.)
 2. Teach patient about the medication change without referral to the Education Center.

6. Failure to Attend Consult

If the patient fails to attend pharmacy consult, the Nurse Clinician will be notified and the patient will be rescheduled for the next available session.

EXCEPTIONS:

- a. Patients who have had pharmacy consults at Cooperative Care within 6 months and who are still taking the same medications (dose, time, etc.) do not need a consult unless the Nurse Educator or Nurse Clinician deem it necessary. However, these patients should be listed on the Education Center schedule as phone consults so that the pharmacist can call to reinforce information, discuss problems, etc.

- b. Practicing physicians do not need consults unless requested.

B. SHORT TERM DIRECT ADMISSIONS

1. Preparation

On admission to Cooperative Care, the Nurse Educator will:

- a. Ascertain from the patient, medications currently taking
- b. pull medication sheets for these medications

2. Self-Administration of Medication Orientation

As part of the orientation process, the Nurse Educator will conduct an orientation to SAM that includes:

- a. Educational philosophy of Cooperative Care: provide patients with varied professional assistance for them to learn all about their own health care and maintenance. For this reason, we will teach patients about their medications and how to take them during their stay in Cooperative Care where professionals are available to answer questions.
- b. the general format of the medication sheets we have prepared
- c. the plan for the teaching process:

- 1. the patient will get a medication sheet for each medication they will be taking
- 2. the patient is to read/study the sheets
- 3. the patient should bring medication sheets to the appointment with the Nurse Clinician that day.

3. Individualized Self-Administration of Medication Counselling Session

When the patient arrives for appointment, Nurse Clinician will:

- a. review each medication with corresponding sheet emphasizing essential information
- b. ask patient to verbalize pertinent information about each medication.
- c. schedule a review/reinforcement/follow-up appointment if above comprehension is inadequate.

4. Follow-Through

- a. After reviewing each medication and assessing adequacy of knowledge, the Nurse Clinician will place patient in one of three categories:
 - 1. patient can self-administer medication. Nurse Clinician will mail out schedule with verbal reinforcing card to schedule according to medication schedule, nature of medication and patient's condition.
 - 2. patient needs further instruction and reinforcement:
 - a. more review or teaching
 - b. telephone reminder at times of administration

3. patient is unable to self-administer medications at this time.

- b. Nurse Clinician will determine from above categorization whether patient is to start SAM immediately. If so, she gives him the medications, reviews each medication by name and instructions on the label, directs him to check off on his/her schedule each time he/she takes medications, and INSTRUCTS THE PATIENT TO BRING THAT SCHEDULE WITH THE NURSE CLINICIAN APPOINTMENT EVERY DAY.
- c. Nurse Clinician will document the above on the patient chart, by writing SELF and initialling the Medication Sheet each shift.
- d. Nurse Clinician will strive to develop level of SAM competency during Cooperative Care stay for those patients who are unable to self-administer medications initially.

5. New Medication Orders

- a. Nurse Clinician will teach patients about any medication change

6. Patients Staying Longer than 48 hours

If patient is not discharged within three (3) days and meets criteria for consult with pharmacist, the patient will be scheduled for this at earliest possible date

C. LONG TERM DIRECT ADMISSION:

These patients will follow same protocol as TRANSFER PATIENTS

- N.B. Since in most instances, the Nurse Educator does not have access during Orientation and Education Assessment to physician order sheet, Medication Information Sheets will be given to patients on basis of their statement of current medications. If physician orders differ from patient's list of medications, the Nurse Clinician should give these sheets to patient.

REVISED: 2/15/82, 3/15/82, 4/15/82, 5/15/82, 6/15/82

NEW YORK UNIVERSITY MEDICAL CENTER
UNIVERSITY HOSPITAL

NURSING DEPARTMENT
POLICY MANUAL

TITLE: Intravenous Therapy - "Butterfly" Lines

All professional nurses will be taught the initiation of butterflies for the administration of intravenous therapy during their orientation to the Cooperative Care Therapeutic Center.

After demonstrating an ability to appropriately insert "Butterfly" intravenous lines, it will be an expectation that those professional RNs assigned to the Therapeutic Center will change or initiate those lines when indicated.



NEW YORK UNIVERSITY MEDICAL CENTER

Interoffice Communication

July 15, 1983

TO: All Therapeutic Center Nurse Clinicians
FROM: Anthony J. Grieco, M.D., Medical Director

When a patient in Cooperative Care requires some form of isolation, if the order for isolation has not been entered by the physician, then the Therapeutic Center Nurse Clinician should enter the order for isolation as a verbal order of the Medical Director.

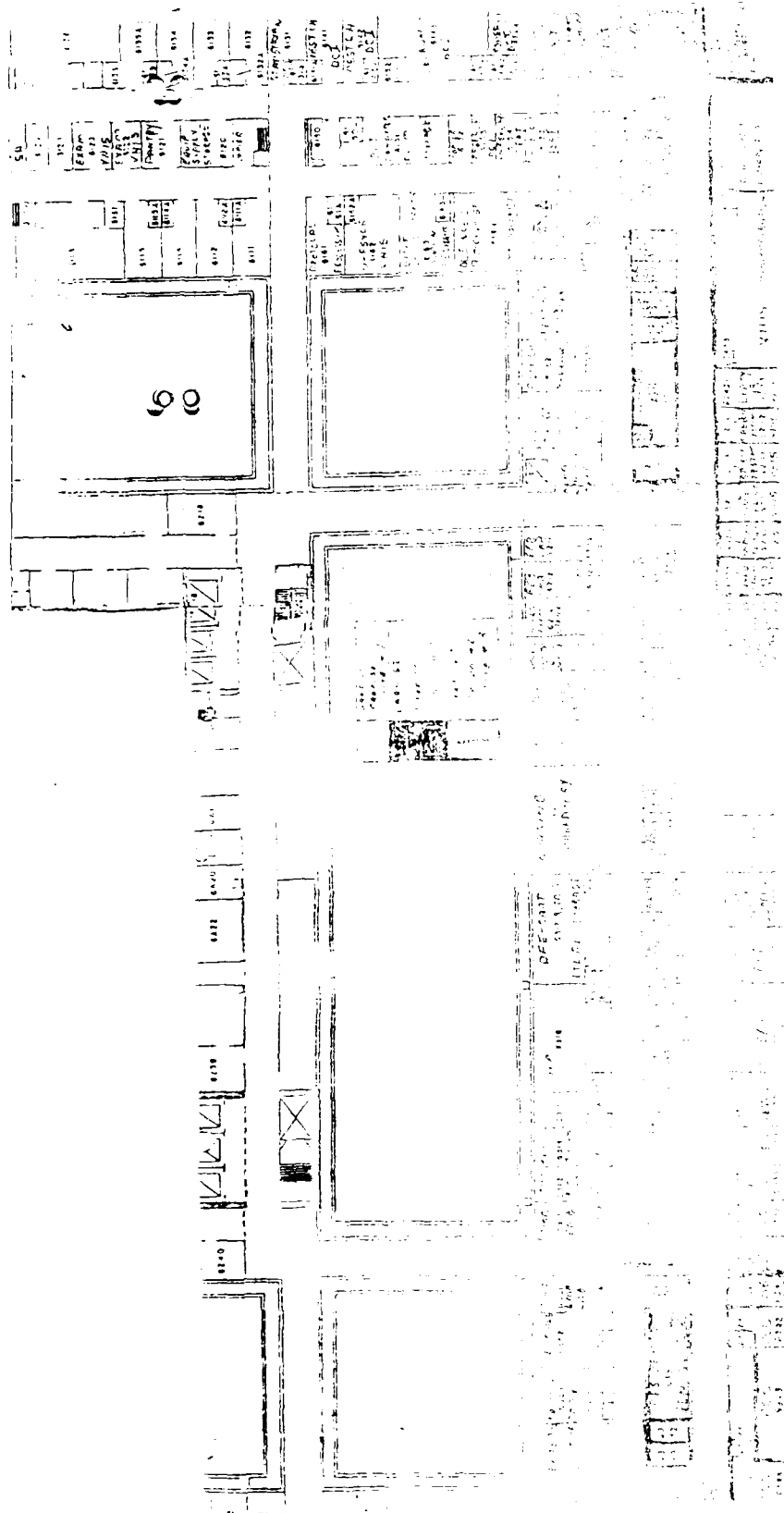
Thank you for your cooperation.

AJG/dd

APPENDIX C

Proposed Location of Nurse
Administered Unit at WRAMC

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contain any legible reproduction



SUBJECT: Location of the Nurse Administered Unit at WRAMC

1. Space is acknowledged as being at a premium at Walter Reed AMC. The establishment of a twelve bed, Nurse Administered Unit would mean re-allocation of space currently occupied by other personnel at Walter Reed AMC. The addition of the patient care unit with the potential benefits to patients, the addition of MCCUs to the hospital, and the service to the staff would make the relocation of the existing personnel cost effective. At the time when the space was allocated for administrative purposes, additional patient care areas were not being sought.

2. Other requirements needed to support the patient unit would be the following:

1. nursing station
2. clean room & dirty room
3. patient day room/class room
4. kitchen pantry
5. office space for nursing personnel

3. Examples of three possible locations for the Nurse Administered Unit have been located on wards 61, 62, or 63. A diagram of the proposed sites is attached to this form.

1. Ward 61

Currently, ward 61 is being used as a 24-bed minimal care unit with the remainder of space used by Clinical Investigation offices and the Vietnam Head Injury Study. The termination of the Vietnam Head Injury study was projected for September 1984. There are tentative plans to move the neurology ward 52 to this unit. The plans include moving the minimal care patients and Clinical Investigation to Bldg 1. Should this move be accomplished, the 12-bed Nurse Administered Unit could share the 45-bed unit with the neurology ward. From September 1984 through February 1985, the census of ward 52 has averaged 26-27 patients. The remaining beds could be assigned to the Nurse Administered Unit. The back section of the ward is divided by a set of firedoors. Room 6155 could be designated as the nursing office with the required patient rooms located on each side. Areas such as utility rooms and kitchen pantry would be shared with ward 61. The existing rooms could be reallocated to the Nurse Administered Unit in the following manner:

Present Use	Proposed Use
6144 DCI	Patient bed (2)
6145 DCI	Patient bed (2)
6146 DCI Supply room	Patient bed (4)
6147 DCI Conference Room	Patient class room

6155 N-psych test	Nursing Office
6156 DCI	Classroom
6154 N-psych test	Patient bed (2)
6164 DCI	Patient bed (2)

2. Ward 62

This area contains no occupied bed space. The nursing station is being used as a reception area for the neurology clinic testing areas. The existing areas could be reallocated to a Nurse Administered Unit in the following manner:

Present Use	Proposed Use
6230 reception desk	nursing station
6231 VHIS	Patient bed (1)
6232 VHIS	Patient bed (1)
6233 VHIS	Patient bed (1)
6241 VHIS	Patient bed (1)
6242 VHIS (speech testing)	Patient bed
6243 VHIS (speech testing)	Patient bed
6244 VHIS admininstratioin	Patient bed (4)
6245 VHIS	Patient bed (4)
6251 Neurology student room	nursing offices
6252 storage VHIS	utility room
6253 storage VHIS	utility room
6254 VHIS equipment room	patient classroom
6255 NCOIC-DCI	patient classroom
6147 Conference room (DCI/VHIS)	share with 61

3. Ward 63

The space occupied by the Pain Control Clinic could be efficiently converted to a Nurse Administered Unit. With the departure of COL Graziano, the PCC area is being used primarily as office/administrative space. The conversion of the following occupied rooms would provide a possible location for the NAU:

Present Use	Proposed Use
6350	Nursing Station/reception area
6350A	Medication room
6351 gen surg sleep room	nurses offices
6352 stoma storage	clean utility room
6353 stoma storage	soiled utility room
6320 Equipment Storage room	Patient Education Classroom
6321 pantry (breast feeding)	pantry for patients
6331 PCC	Patient bed (1)
6341 PCC	Patient bed (1)
6342 PCC	Patient bed (1)
6343 PCC	Patient bed (4)
6344 PCC	Patient bed (2)

6345 PCC

Patient bed (1)

6464 Duty Officer Bedroom

Patient bed (4)

APPENDIX D

Proposed Staffing for
Nurse Administered Unit
at WRAMC

SUBJECT: Project Staffing for Nurse Administered Unit

The number and the mix of staff recommended for a twelve bed, nurse administered unit were computed using staffing guides available to the Nurse Methods Analyst at Walter Reed Army Medical Center, Washington, DC. The job descriptions of the professional nursing staff is included in this appendix.

Rank	Education	Title
(1) LTC	PhD	Nurse Administrator
(1) MAJ	MSN	Assistant Director
(3) CPT	BSN/MSN	Clinical Staff Nurse
(2) 1LT	BSN	Clinical Staff Nurse
(2) GS11	MSN	Clinical Specialist

Requirements for the Paraprofessional staff would be as follows:

(1) 91C30	NCOIC
(6) 91A	Medical Specialist

In addition to the nursing personnel, clerical support would be requested. Four MRTs, GS4 would be needed to provide coverage for the day and evening shifts. Housekeeping would have to make adjustments in work assignments to cover the routine housekeeping chores on the usual medical/surgical unit.

APPENDIX E

Proposed Needed Equipment
for Nurse Administered Unit
at WRAMC

SUBJECT: Equipment Projected for Nurse Administered Unit

Setting up the unit would require the standard as well as additional equipment needed in the rehabilitation of patients. The following equipment is projected for use in the Nurse Administered Unit:

1. Twelve patient beds, bedside tables, overbed tables, chairs, television monitors, and footstools
2. Privacy curtains for each patient area (12 sets)
3. Chartbacks (12-15), chartback holders (1-2)
4. CPR and Spark Kit
5. Wheelchairs (2), Gerichairs (3), stretcher (1)
6. IMEDD infusion pump (2) Keofeed pumps (2)
7. Patient scale
8. Videoplayer (1), overhead projector (1), slideprojector (1)
9. Conference table and chairs, nurses' desks (3) and chairs (6)
10. Whirlpool bath equipment (1)

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